U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 17 July 2006

CASE NO. 2005-BLA-5135

In the Matter of

JOHN T. SICKON, SR.,
Claimant,

v.

KEYSTONE COAL MINING,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Robert J. Bilonick, Esquire
For the Claimant

George H. Thompson, Esquire
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claimant's subsequent claim after a denial of his prior claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (the Act). (DX 1).[1] The Act and implementing regulations, 20 C.F.R. Parts 410, 718, and 727 (Regulations), provide compensation and other benefits to coal miners who are totally disabled by pneumoconiosis and to the surviving dependents of coal miners whose death was due to pneumoconiosis.

[1] In this Decision, "DX" refers to Director's exhibits; "CX" refers to Claimant's exhibits; "EX" refers to Employer's exhibits and "TR" refers to the transcript of the hearing held herein on November 2, 2005.

The Act and Regulations define pneumoconiosis (commonly known as black lung disease, coal workers' pneumoconiosis, or CWP) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101.

PROCEDURAL HISTORY

Claimant filed his first claim for benefits with the Department of Labor (DOL) on February 14, 1995. (DX 1). The claim was denied on August 11, 1995. (DX 1). The Claimant did not appeal that decision. On August 14, 2003, the Claimant filed his second application for benefits. (DX 3). Because it was filed more than one year after the prior denial, it is a subsequent claim governed by § 725.309. The District Director issued a Proposed Decision and Order on July 29, 2004, in which he denied the claim for failure to establish the existence of pneumoconiosis arising out of coal mine employment or total disability due to the disease. (DX 31). On August 3, 2004, Claimant objected to the findings of the District Director and requested a formal hearing before an ALJ. (DX 32).

On November 2, 2005, I held a hearing in Pittsburgh, Pennsylvania. The Claimant and Employer, both represented by counsel, were afforded the full opportunity to present evidence and argument. I admitted Director's exhibits 1–37, Claimant's exhibits 1–7, and Employer's exhibits 1-6. (TR 5–8). Employer was afforded additional time, post-hearing, in which to submit evidence. Employer has submitted the deposition transcripts of Drs. Fino and Renn, which are marked and admitted as Employer's exhibits 7 and 8, respectively.

The parties stipulated to Employer's proper designation as the Responsible Operator, to fourteen years of qualifying coal mine employment by the Claimant, and to the qualification of one dependent, Claimant's wife Anna, for purposes of augmentation of benefits. (TR 9).

ISSUES

(1) Whether the evidence establishes a change in a condition of entitlement pursuant to 20 C.F.R. § 725.309(d), and if so:
(2) Whether the miner has pneumoconiosis;
(3) Whether the miner's pneumoconiosis arose out of his coal mine employment;
(4) Whether the miner is total disabled; and
(5) Whether the miner's total disability is due to pneumoconiosis.

(DX 37; TR 9).

FINDINGS OF FACT

Length of Coal Mine Employment

Employer has conceded to fourteen years of coal mine employment. (TR 9). Claimant alleges at least twenty-four years of coal mine employment. (DX 3; TR 7). The District Director found twenty-two years of coal mine employment. (DX 31). I find, based upon the documented

evidence of record, including the Social Security Administration's Itemized Statement of Earnings, that Claimant was a coal miner within the meaning of the Act and Regulations for twenty-two years. (TR 7; DX 5-8).

Responsible Operator

The parties agree, and I find that Keystone Coal Mining is the last employer for whom the Claimant worked a cumulative period of at least one year. (TR 9). Therefore, Employer is the properly designated responsible coal mine operator in this case.

Dependents

I find that Claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Anne. (DX 3, 10; TR 11).

Claimant's Testimony

The Claimant was born on March 21, 1938, and he has a high school education. (DX 3; TR 10-11). He testified that he worked as a coal miner for twenty-four and a half years. All but six months of that employment was underground. He worked as a belt patrolman, a fireboss, and a belt repairman. His very last job was that of a hyster man for six months. In that capacity he moved supplies and cleaned out supply cars. (TR 12). He also took care of the tipple belt and loaded trucks. (TR 12). He stopped working after suffering a back injury. (TR 13). He suffered a stroke in December of 2004. (TR 13).

Claimant testified to problems breathing, which began around 1988. (TR 14). He is being treated by Dr. Bagley, and his family doctor is Dr. Muthappan. (TR 15, 19). He is on Spiriva and Albuterol. (TR 16). Claimant has never smoked cigarettes. (TR 17). Claimant had triple bypass surgery in 1993. (TR 20).

Claimant's wife also testified. (TR 29-30). She stated that she had been married for forty-seven years to the Claimant. She had noticed that Claimant has a breathing problem as well as coughing problem, the latter of which she characterized as being "pretty bad at times." (TR 30). She testified to washing Claimant's handkerchiefs.

Applicable Law

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202–718.205; *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

Subsequent Claim

The Claimant's last work as a coal miner was within the State of Pennsylvania, which is located within the jurisdiction of the Third Federal Circuit. The Benefits Review Board applies the law as it is interpreted by the applicable Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989).

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. *See* 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim, which is denied on the basis of the prior denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d). Under this regulatory provision, according to the Court of Appeals for the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993, 997–998 (6th Circuit 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

The Court of Appeals for the Third Circuit, which has jurisdiction over this claim, has followed the *Sharondale* approach. *Labelle Processing Company v. Swarrow*, 72 F.3d 308 (3rd Cir. 1996). I interpret the *Sharondale* approach to mean that the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Circuit 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

The amended Regulations make clear that the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. 20 C.F.R. § 725.309(d)(2). In the denial of the miner's prior claim, it was found that he had failed to establish the existence of pneumoconiosis arising out of coal mine employment and that he failed to establish that he was totally disabled due to pneumoconiosis. Therefore, my inquiry begins with an investigation of whether the newly submitted evidence establishes an element previously adjudicated against the Claimant. The medical evidence is set forth below.

Medical Evidence

Chest X-rays

Exh. #	X-ray Date	Physician/Qualifications[2]	Interpretation
DX 15	7/14/03	Schaaf	No mention pneumo
DX 21	7/14/03	Pendergrass, B BCR	Negative
DX 19	10/23/03	Boron, BER	p/p, 0/0
DX 20	10/23/03	Navani, B BCR	Quality 1
DX 30	10/23/03	Pendergrass, B BCR	Negative
EX 4	3/18/04	Hayes, B BCR	No pneumo
EX 1	12/15/04	Fino, B	No pneumo
EX 2	4/12/05	Renn, B	No pneumo

Additionally, in his deposition testimony, Dr. Begley stated that he reviewed the October 23, 2003 x-ray and found it to be positive for simple pneumoconiosis. (CX 7). Dr. Begley is an A-reader. Dr. Begley did not render a classification of that disease process pursuant to the ILO classification system, however.

[2] The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. § 37.51 (1982).

The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii).

Pulmonary Function Studies

Exh. #	Date	Age/Height[3]	FEV1	MVV	FVC	Physician
DX 15	7/11/03	65/70"	2.54 2.65*	44 96*	4.22 4.52*	Schaaf
DX 18	10/23/03	65/70"	2.32	98	3.81	Illuzzi
EX 1	12/15/04	66/69"	2.46 2.62*		4.44 4.54*	Fino
EX 2	4/12/05	67/69"	2.22 2.43*	72 79*	3.51 3.98*	Renn

* denotes post-bronchodilator

Arterial Blood Gas Studies

Exh. #	Date	pCO2	pO2
DX 17	10/23/03	35.5 36.5*	87.9 91.2*
EX 6	12/8/04	33 35	95 93
EX 1	12/14/04	35	85
EX 2	4/12/05	31	82

* denotes post-exercise

Physicians' Reports

Dr. John T. Schaaf

On July 14, 2003, Dr. John T. Schaaf examined Claimant. (DX 15). Dr. Schaaf is board-certified in internal medicine, pulmonary medicine, and critical care medicine. Dr. Schaaf diagnosed chronic bronchitis which he found to be related to Claimant's coal mine employment. He classified it as industrial bronchitis. In his opinion, Claimant's dyspnea was due to moderate obstructive airways disease which was associated with and due to his chronic environmental bronchitis. Dr. Schaaf found Claimant incapable of performing his coal mine work, based on these findings. While Dr. Schaaf acknowledged that Claimant had coronary artery disease, he found Claimant's left ventricular function to be normal, and therefore, he was unwilling to blame his heart for his breathlessness. In his report, Dr. Schaaf recorded that Claimant was a life long nonsmoker and that he had been a coal miner from 1968 to 1993. Claimant underwent coronary bypass graft surgery in 1993, hospitalizations in 1991 and 1992 for his back, and heart problems in 1992. Dr. Schaaf conducted an examination which included the taking of a chest x-ray and

[3] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983). As there is a variance in the recorded height of the miner, I find that Claimant was 69.5" in height, in determining whether the studies qualify to show disability under the regulations.

pulmonary function study. His Impression included chronic bronchitis and moderate obstructive airways disease. As Claimant was a nonsmoker, Dr. Schaaf suspected that his chronic bronchitis was related to his coal mine employment. The chronic bronchitis was characterized as relatively mild. The obstructive airways disease was associated with chronic bronchitis and, therefore, they were related. Other diagnosed conditions included (1) dyspnea due to moderate obstructive airways disease; (2) coronary artery disease status post coronary artery bypass graft surgery with preserved left ventricular function; (3) hypertension; and (4) diabetes.

The deposition testimony of Dr. Schaaf was taken on February 18, 2005. (CX 4). Dr. Schaaf testified that he had reviewed additional medical evidence since his examination of the Claimant. He found Claimant's symptoms to be consistent with obstructive airways disease and bronchitis. According to Dr. Schaaf, the pulmonary function studies conducted by Drs. Begley and Illuzzi had basically the same findings as his testing. He opined that Dr. Illuzzi's report listed symptomatology which was consistent with chronic bronchitis, namely, daily wheezing, cough, and sputum production. Dr. Schaaf reiterated his opinion that the Claimant's chronic obstructive pulmonary disease was associated with his coal dust exposure. When reviewing the opinion rendered by Dr. Fino, Dr. Schaaf stated his disagreement with Dr. Fino's finding that Claimant's lung disease was mild to very mild, as he classified it as moderate. Upon cross-examination, Dr. Schaaf stated that he did not recall reviewing a history of congestive heart failure in this miner and conceded that it is a condition which can cause breathlessness and shortness of breath. Dr. Schaaf stated his disagreement with the finding rendered by Dr. Illuzzi, that Claimant's moderate obstructive defect only contributed a small portion to his overall disability, as well as Dr. Fino's opinion that the Claimant's moderate obstructive defect would not disable him. Dr. Schaaf did not believe that Claimant was disabled from his cardiac condition.

In a report dated April 19, 2005, Dr. Schaaf discussed the GOLD criteria for qualifying lung disease. (CX 5). He stated that patients with moderate obstructive airways disease represent patients who have symptoms which are life-altering. (CX 5). Dr. Schaaf stressed that, in his opinion, Claimant was incapable of doing his last job because of his moderate obstructive airways disease and the effect it had on his overall functional capacity.

Dr. Angelo Illuzzi

On October 23, 2003, Dr. Angelo Illuzzi examined Claimant. (DX 16). He recorded coal mine employment from 1969 to 1991 and noted that Claimant had smoked one box of cigars in his entire life and had quit smoking. Claimant's chief complaints were listed as sputum, wheezing, dyspnea, cough, chest pain, orthopnea, ankle edema, and paroxysmal nocturnal dyspnea. Based upon his examination, which included the taking of a chest x-ray, pulmonary function study, and blood gas testing, Dr. Illuzzi diagnosed moderate obstructive airways disease, ischemic heart disease, and coronary artery disease. Dr. Illuzzi found the first condition to be due to chronic dust exposure, while the coronary artery disease was secondary to "HTN and DM." He found the hypertension to be essential. Dr. Illuzzi opined that Claimant was unable to perform his prior coal mine work but that Claimant's lung disease contributed only a small portion to his disability. He found Claimant to be primarily disabled due to heart disease, obesity, hypertension, and deconditioning.

Dr. Christopher J. Begley

On December 8, 2004, Dr. Christopher J. Begley examined Claimant. (CX 1). He also had the opportunity to review records, including the reports of Drs. Schaaf and Illuzzi, x-ray evidence, and records which predate the instant claim. The latter records are not before me at this juncture.

Based upon his examination and review of the evidence, Dr. Begley opined that Claimant suffered from coal workers' pneumoconiosis. He based this conclusion on the history of exposure to coal dust, the fact that Claimant had chronic bronchitis and significantly abnormal pulmonary function studies, and the radiographic evidence of simple coal workers' pneumoconiosis. Dr. Begley explained that Claimant had no history of tobacco use to explain his symptoms of chronic bronchitis and his abnormal pulmonary function studies. However, he did have a significant exposure to coal dust while working in the mining industry. He concluded that Claimant's pulmonary impairment precluded him from performing his last coal mine employment. He based this conclusion on the findings of moderate obstructive lung disease by pulmonary function test criterion and the requirement for moderate to heavy exertion in Claimant's last coal mine work. Dr. Begley is board-certified in internal medicine, pulmonary disease, and critical care medicine.

In a Supplemental Report dated January 26, 2005, Dr. Begley stated that it was his opinion that Claimant suffered from simple coal workers' pneumoconiosis. (CX 3). He based this conclusion on the fact that Claimant had appropriate occupational exposure to coal dust while working in the coal mining industry for approximately twenty-four years and the presence of simple pneumoconiosis by chest x-ray. He also opined that Claimant suffered from a significant pulmonary impairment due to that exposure, basing his opinion on the factors listed above as well as the fact that Claimant had never used tobacco products. Dr. Begley stated that his opinion was based on a careful history and physical examination, a review of the October 23, 2003 chest x-ray, and a review of the December 8, 2004 pulmonary function studies.

The deposition testimony of Dr. Begley was taken on August 17, 2005. (CX 7). Dr. Begley stated that he saw Claimant as the result of a referral from Dr. Muthappan. Claimant complained of shortness of breath, a chronic daily cough productive of yellow to gray secretions, paroxysmal nocturnal dyspnea, and two pillow orthopnea. A history was taken and a physical examination was conducted. Dr. Begley stated that his review of the October 23, 2003 chest x-ray revealed simple pneumoconiosis. Claimant also had evidence of previous coronary bypass surgery. Pulmonary and blood gas testing was conducted. Dr. Begley diagnosed moderate obstructive lung disease, simple coal workers' pneumoconiosis, and chronic bronchitis. He found the bronchitis and the pneumoconiosis to be secondary to coal dust exposure. Dr. Begly stated that he also reviewed extensive medical evidence. It did not alter his opinion. Claimant was disabled from his prior coal mine employment as a result of his pulmonary impairment which was a direct consequence of his coal dust exposure. Claimant's cardiac status was not a contributing factor to his pulmonary dysfunction, as cardiac surgery would cause restriction and not obstruction. While patients with congestive heart failure can have obstruction, Claimant was not in congestive heart failure when he was seen. Dr. Begley found no cardiac disability in this

case. There was no chest pain, no evidence in Claimant's history of cardiac dysfunction, and normal ejection fraction on echocardiogram. Dr. Begley did not attribute Claimant's pulmonary impairment to his obesity, citing the fact that obesity would cause a restrictive lung disease, not an obstructive lung disease. Dr. Begley stated that he found Claimant's chronic obstructive pulmonary impairment to be due to coal mine dust exposure because Claimant had no history of smoking, no demonstrable asthma, and no evidence of congestive heart failure. Dr. Begley conceded that, in a general sense, shortness of breath can be related to deconditioning and obesity and that chronic bronchitis can be the result of repetitive respiratory infections. Cardiac ischemia can also contribute to shortness of breath.

Dr. Begley stated that when Claimant was in his office, he had edema of the extremities, which is an indicator of right sided congestive heart failure. Dr. Begley conceded as well that Claimant was on cardiac medications. Claimant also had rhonci and a murmur. Dr. Begley subsequently testified that Claimant did have a disability from a cardiac standpoint.

Dr. Gregory J. Fino

Dr. Gregory Fino examined Claimant on December 15, 2004. (EX 1). Dr. Fino also had the opportunity to review medical records and prior reports. Twenty-five years of coal mine employment were recorded, all but one of those years having been spent underground. Claimant's breathing problem was characterized as shortness of breath. Claimant complained of chest pain and wheezing. Claimant did not admit to daily cough or mucus production and did not complain of orthopnea or paroxysmal nocturnal dyspnea. Past medical history included coronary bypass surgery, diabetes mellitus, work-related back injuries, breathing difficulties resulting in hospitalization, high blood pressure, history of chronic bronchitis, probable pneumonia one time, upper digestive problems a few years ago, and arthritis. Based upon his examination, which included the taking of histories, a chest x-ray, pulmonary function studies, and blood gas testing, Dr. Fino diagnosed mild chronic pulmonary disease due to coal mine dust exposure without radiographic evidence of coal workers' pneumoconiosis. He found mild to very mild respiratory impairment present and did not believe that it prevented Claimant from performing his last coal mine job. Dr. Fino concluded that there was a coal mine-dust related abnormality present and that there was a mild to very mild respiratory impairment present. He found Claimant to be disabled due to coronary artery disease. Coal mine dust inhalation played no part in his disability. In his report, Dr. Fino reviewed the pulmonary function studies conducted and submitted with the prior claim, finding the two studies conducted in 1995 to be invalid. He also noted Claimant's smoking history as related to various physicians, it varying from one to one and a half cans of snuff per day, to smoking until the 1990s, to never having smoked. Dr. Fino is board-certified in internal medicine and pulmonary disease.

The deposition testimony of Dr. Fino was taken on September 20, 2005. (EX 7). Dr. Fino testified that he was provided a variety of smoking histories, one of which indicated a pack a day for thirty years. Dr. Fino testified, however, that many other records he reviewed indicated Claimant had a negative smoking history. According to Dr. Fino, there were some wheezes bilaterally upon examination of the lungs, indicating some narrowing of the breathing tubes. Claimant complained of shortness of breath without daily cough and mucus production which had been getting increasingly worse over time. He also complained of wheezing. These

complaints signified there was a lung condition present. Dr. Fino reiterated his opinion as noted above. He also testified that he had the opportunity to review the results obtained by Dr. Begley in his pulmonary function testing, which occurred seven days before Dr. Fino's examination. He found those values to be within normal limits. Dr. Renn, whose findings are set forth below, obtained values a little lower than those of Dr. Fino, however, Dr. Renn's study did show a 13% improvement following bronchodilators. This was significant because occupational pneumoconiosis does not improve following bronchodilators.

Dr. Fino reiterated that in his opinion, Claimant's major disease problem was his significant coronary artery disease. Dr. Fino found Claimant's pulmonary symptoms to be far greater than what could be explained on the basis of the pulmonary function testing. Claimant was not disabled from his last coal mining job from a pulmonary standpoint; he was disabled due to his coronary artery disease. Dr. Fino noted that Dr. Renn thought there was asthma present. Dr. Fino stated that he could not argue against a component of asthma because of the bronchodilator response. Regardless of the cause of the impairment, it was not disabling. When reviewing Dr. Begley's finding of a moderate obstructive defect, Dr. Fino indicated that this "boggles" his mind because the FEV1 was 87% of predicted, and the standards for interpreting pulmonary function studies would say that this could even be interpreted as a normal pulmonary function study, but at most, very mild to mild. Dr. Fino also disagreed with Dr. Illizu's findings on pulmonary function testing, noting that an FEV1 of 75% would be listed as mild.

Dr. Joseph J. Renn III

Dr. Joseph Renn examined Claimant on April 12, 2005. (EX 2). Dr. Renn is board-certified in internal medicine and pulmonary disease. He took work, social, medical, and family histories. Dr. Renn stated that Claimant had exertional dyspnea and shortness of breath since 1988, as well as a daily cough and occasional wheezing. Claimant also suffered from two pillow orthopnea and had a myocardial infarction in 1993 which resulted in triple coronary artery bypass grafting. He had suffered from hypertension since 1956. Medical records were reviewed as was Claimant's history of tobacco usage. Dr. Renn indicated that Claimant was unable to tell him when he began smoking, however, he believed he quit smoking in the 1960s, having smoked a box of cigars during his lifetime. Claimant denied smoking cigarettes or a pipe. He did use half a box of snuff daily from 1950 to 1991. Dr. Renn noted that past medical records listed a variety of smoking histories ranging from having been a nonsmoker to having smoked in the past to having used up to one and one half cans of snuff daily prior to quitting in 1993.

Based upon his examination, which included the taking of a chest x-ray, pulmonary function study, and blood gas testing, Dr. Renn concluded that Claimant suffered from mild asthma. He did not find that pneumoconiosis was present. He did find a mild, significantly bronchoreversible obstructive ventilatory defect due to asthma and the presence of Claimant's ASCVD, chronic congestive heart failure, and systemic hypertension. Also diagnosed were atherosclerotic peripheral vascular disease, GERD, EHH, severe exogenous obesity, hyperlipidemia, insulin dependent diabetes mellitus, and left hemispheric cerebrovascular accident with the sequela of right hemiparesis. Dr. Renn found that none of the diagnosed conditions were caused or contributed to by Claimant's exposure to coal mine dust. He found Claimant's exertional dypsnea/shortness of breath to be due to intrinsic asthma, ASCVD, chronic

congestive heart failure, systemic hypertension, severe exogenous obesity, and physiologic deconditioning. When considering only his respiratory system, Dr. Renn found Claimant was not totally and permanently disabled to the extent that he would be unable to perform his last known coal mining jobs of belt patrolman or Hyster man or any similar work effort.

The deposition testimony of Dr. Renn was taken on December 2, 2005. (EX 8). Dr. Renn reiterated his opinion as set forth above. He also stated that the only respiratory system abnormality he found in the Claimant was his asthma. Claimant had neither clinical nor legal pneumoconiosis. Claimant had bronchoreversibility, which is not seen with coal workers' pneumoconiosis. He had air trapping consistent with asthma. Neither his residual volume nor his diffusing capacity were indicative of coal workers' pneumoconiosis. His arterial blood gases were also normal. He had a negative chest x-ray. Claimant's primary disability was the result of his stroke, his heart disease, and diabetes mellitus. He was also short of breath due to his obesity. From a respiratory standpoint, Claimant was not disabled from his prior coal mine work.

Treatment Records

Treatment records from 1999 to 2004 have been submitted. (EX 3). Dr. Muthappan was the treating physician. In May of 1999, Claimant was hospitalized for marked cough, difficulty breathing, fever, and possible pneumonia. Past medical history was listed as including a history of COPD for which Claimant was on multiple medications. He also had a history of diabetes mellitus, obesity, and hyperlipidemia. Personal history included no history of smoking or chewing at this time, but the Claimant used to do both in the past. Claimant had a history of coronary artery disease and coronary artery bypass surgery. The diagnosis on discharge included chronic obstructive pulmonary disease with acute exacerbation, along with history of coronary artery disease, history of coronary artery bypass surgery, history of diabetes mellitus, Type 2, history of degenerative arthritis including lumbar spine, history of hypertension, history of obesity, and history of gastroesophageal reflux disease. It was noted that chest x-rays failed to reveal pneumonia.

In July of 2000, Claimant was hospitalized for severe low back pain. (EX 3). It was found to be due to degenerative arthritis. In February of 2002, Dr. Muthappan recorded that Claimant was hospitalized with acute respiratory failure secondary to severe respiratory infection. (EX 3). It was recorded that Claimant was known to have severe COPD, and "on top of it," Claimant was also obese. Other medical problems were recorded as coronary artery disease and bypass surgery. Claimant had a history of chewing tobacco, though not in the last five years. The diagnosis upon discharge included chronic obstructive pulmonary disease with acute exacerbation, history of coronary artery disease, history of diabetes mellitus, history of congestive heart failure, history of recurrent urinary tract infections, history of benign prostatic hypertrophy, history of degenerative joint disease, and history of lumbosacral degenerative disc disease. Attached to this record were several x-ray readings which were not read for the purposes of diagnosing pneumoconiosis. It was noted that the lungs revealed no acute infiltrates or pulmonary edema on two of the x-rays. Two other x-rays listed mild pulmonary hypertension.

In a hospitalization which occurred in September of 2002, the Claimant was admitted because of chronic obstructive pulmonary disease with acute exacerbation and congestive heart failure uncompensated, possibly right sided. (EX 3). The Final Diagnosis by Dr. Muthappan included (1) congestive heart failure, uncompensated clinically improved on discharge; (2) significant venous edema, possibly secondary to congestive heart failure, namely right-sided. Additionally, it could be secondary to several medications including Actos, Vioxx, and calcium channel blocker, Procardia. Listed as "Other Diagnoses" were (1) known history of chronic obstructive pulmonary disease; (2) known history of lumbosacral degenerative joint disease and several other degenerative joint diseases; (3) history of hypertension; (4) history of diabetes mellitus, Type 2; (5) history of coronary artery disease; (6) history of coronary artery bypass surgery; (7) history of peripheral neuropathy; and (8) history of peripheral artery disease. A chest x-ray reading was included with the records, which makes no mention of pneumoconiosis, finding the lungs to be clear.

Claimant was hospitalized again in December of 2004, complaining of right-sided upper, more than lower, extremity weakness. (EX 3). The Final Diagnosis included (1) acute cerebrovascular accident; (2) history of uncontrolled diabetes mellitus and hypertension; (3) history of obesity; (4) history of coronary artery disease; (5) history of degenerative joint disease; (6) history of gastroesophageal reflux disease; and (7) history of lumbosacral degenerative joint disease and disk disease. Handwritten pages included in this exhibit are illegible.

Claimant was admitted for rehabilitation after his last hospitalization in December of 2004. (EX 5). The assessment from Dr. Laura Shymansky included cerebrovascular accident, history of diabetes mellitus, chronic obstructive pulmonary disease, and coronary artery disease. Handwritten pages are illegible.

CONCLUSIONS OF LAW

Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202–718.205; *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Evidence which is in equipoise is insufficient to sustain the Claimant's burden of proof. *Director, OWCP v. Greenwich Collieries, et al.*, 512 U.S. 267 (1994); *aff'g sub nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir. 1993).

Pneumoconiosis

The regulations define pneumoconiosis broadly, as "a chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment." 20 C.F.R. § 718.201. The definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* Clinical pneumoconiosis comprises:

> Those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silico-tuberculosis, arising out of coal mine employment.

Id. Legal pneumoconiosis, on the other hand, includes "any chronic lung disease or impairment and its sequelae" if that disease or impairment arises from coal mine employment. *Id.* A claimant's condition "arises out of coal mine employment" if it is a "chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* Finally, the Regulations reiterate that pneumoconiosis is "a latent and progressive disease" that might only become detectable after a miner's exposure to coal dust ceases. *Id.*

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987). However, this rule is not mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320.

The regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant has pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)–(4). Under § 718.202(a)(1), the existence of pneumoconiosis can be established by chest x-rays conducted and classified in accordance with § 718.102. It is well-established that the interpretation of an x-ray by a B-reader may be given additional weight by the fact-finder. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32, 34 (1985); *Martin v. Director, OWCP*, 6 B.L.R. 1-535, 537 (1983); *Sharpless v. Califano*, 585 F.2d 664, 666-7 (4th Cir. 1978). The Benefits Review Board has also held that the interpretation of an x-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. *Scheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 131 (1984). In addition, a judge is not required to accord greater weight to the most recent x-ray evidence of record, but rather, the length of time between the x-ray studies and the qualifications of the interpreting physicians are factors to be considered. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Pruitt v. Director, OWCP*, 7 B.L.R. 1-544 (1984); *Gleza v. Ohio Mining Co.*, 2 B.L.R. 1-436 (1979).

In the instant case, the only positive reading was that by Dr. Begley, who is neither a board-certified radiologist nor a B-reader. By contrast, every other reading, all of which were rendered by B-readers and/or board-certified radiologists, was negative for the presence of pneumoconiosis. Based upon the preponderance of negative readings by the more highly qualified physicians, I find that the weight of the x-ray evidence fails to establish the existence of pneumoconiosis.

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is unavailable here, because the current record contains no such evidence.

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires x-ray, biopsy or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth as follows in subparagraph (a)(4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

In this case, Drs. Illuzzi, Schaaf, and Begley specifically find pneumoconiosis to be present. Dr. Fino also found that Claimant suffered from a mild chronic pulmonary disease due to coal mine dust exposure. Dr. Renn finds the disease to be absent. Based upon the preponderance of medical opinions finding a coal mine dust related condition to be present, I find that Claimant has established the existence of coal workers' pneumoconiosis by means of the medical opinion evidence. I do not find this to be outweighed by the contrary probative evidence of record. Accordingly, I find that pneumoconiosis has been established pursuant to 20 C.F.R. § 718.202(a).

Cause of Pneumoconiosis

Once pneumoconiosis has been established, it must also be established that the miner's pneumoconiosis arose, at least in part, out of his coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment. In this case, twenty-two years of coal mine employment has been established. I find that Claimant is entitled to the rebuttable presumption at § 718.203. I further find that the evidence is not sufficient to rebut the presumption. Therefore, the next issue to be determined is whether the miner is totally disabled due to the disease. Additionally, since Claimant has established an element previously found against him, the evidence submitted in his prior claim must be considered.

That evidence includes a report from Dr. Muthappan dated March 2, 1993, wherein he noted that Claimant had a history of tobacco use and presently was chewing almost continuously. A review of systems was remarkable for obesity, mild hard of hearing, with no eye problems, and no other cardiac or pulmonary problems. He was hospitalized at that time because of repeated attacks of chest pain. The hospital records show that Claimant was hospitalized suffering from coronary artery disease, unstable bouts of angina, severe 3-vessel coronary artery disease, hypertension, past history of working in the coal mines, bilateral carpal tunnel syndrome, and past lumbar disk syndrome. (DX 1). It was noted that Claimant was obese. Chest x-rays did not reveal the presence of coal workers' pneumoconiosis. Claimant was listed as a nonsmoker who chewed tobacco. From a pulmonary standpoint, Claimant was found to be very stable. He underwent three vessel coronary artery bypass surgery. On discharge from the hospital, Dr. Muthappan listed a Final Diagnosis of (1) severe occlusive coronary artery disease with unstable angina; (2) history hyperlipidemia; (3) history of hypertension; (4) history of chronic tobacco chewing; (5) history of low back pain secondary to work-related injury; and (6) history of carpal tunnel syndrome secondary to work-related injury.

After an examination conducted on March 21, 1995, Dr. Julian Eligator diagnosed coronary artery disease. The pulmonary function study revealed poor effort and cooperation, the blood gas studies were normal, and the chest x-ray was negative. A blood gas study conducted on May 16, 1995 produced an FEV1 of 1.77, an MVV of 76, and an FVC of 2.24, the miner being 57 years old and 69.25 inches tall. It was found to be invalid by Dr. Gaziano for less than optimal effort, cooperation and comprehension as well as the fact that the studies were improperly performed. I do not find this medical evidence alters the finding noted above, that the more recent evidence establishes that the Claimant has been found to be suffering from coal workers' pneumoconiosis.

Total Disability

Next, the Claimant must show that he is totally disabled by his coal workers' pneumoconiosis. Sections 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (iv) reasoned medical opinions concluding that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the ALJ must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, then the ALJ must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on recon. en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable to this claim because there is no evidence that the Claimant suffers from cor pulmonale with right-sided congestive heart failure. 20 C.F.R. § 718.204(b)(2)(iii). Section 718.204(d) is not applicable because it only applies to a survivor's claim or a deceased miner's claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. A claimant may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies showing an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the bloodstream. 20 C.F.R. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

In the instant matter, I do not find the pulmonary function studies submitted in the prior claim to be probative of Claimant's current condition, nor do I find them sufficient to establish total disability, given that their validity has been questioned. I further find that the more recent pulmonary function studies all failed to produce values indicative of total disability. Accordingly, I find that total disability has not been established pursuant to 20 C.F.R. § 718.204(b)(2)(i).

None of the blood gas studies produced qualifying values. I find that the blood gas study evidence fails to establish total disability by a preponderance of the evidence, pursuant to § 718.204(b)(2)(ii).

Total disability may also be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b). Under this subsection, I must examine all the evidence of record "relevant to the question of total disability due to pneumoconiosis . . . with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201, 1-204 (1986). I must compare the exertional requirements of the Claimant's usual coal mine employment with a physician's assessment of the Claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once the miner has demonstrated that he is unable to perform his usual coal mine work, he has made a prima facie case of total disability; the burden of going forward with evidence to prove that the Claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined at § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

The medical opinion evidence submitted with the prior claim is clearly insufficient to establish total disability due to a respiratory or pulmonary impairment. Of the more recent medical reports, Drs. Begley and Schaaf found Claimant to be totally disabled from his last coal mine work due to his pulmonary impairment. Dr. Illuzzi found that Claimant's lung disease contributed a small portion to his total disability, finding that his heart disease, obesity, hypertension, and deconditioning were the primary causes. Dr. Renn finds total disability due to heart disease, as does Dr. Fino. The hospital records do not assess total disability and its etiology and cannot assist Claimant in this determination. I find, when reviewing the medical opinion evidence of record, that the opinion of Dr. Fino in particular, is worthy of the greatest weight. I further find that, on the issue of disability, it is supported by the findings rendered by Dr. Renn as well as by the objective laboratory data of record and the treatment records.

Thus, while Drs. Schaaf and Begly find a totally disabling pulmonary impairment, their findings are not supported by the objective laboratory data of record, a discrepancy they fail to fully address or explain. Additionally, Dr. Begley initially states that he finds no cardiac disability, only conceding that issue on cross-examination in his deposition testimony. He also discounts Claimant's obesity as a factor in his breathing problems. Similarly, Dr. Schaaf discounts Claimant's heart problems and indicates that he did not recall reviewing a history of congestive heart failure. It does not appear that the opinions of these two physicians are well-reasoned or that these two physicians fully considered all significant factors, when reaching their conclusions. I find that Claimant's pulmonary function testing results do not support the conclusions rendered by Drs. Begley and Schaaf, as I also find that Dr. Fino's assessment of the values obtained is the more persuasive on this issue.

In sum, I find that Drs. Begley and Schaaf do not sufficiently take into account Claimant's heart disease, obesity, and other significant medical conditions when rendering their opinions. Dr. Illuzzi finds that Claimant's lung disease played a small part in Claimant's total disability, an opinion which does not meet Claimant's burden of proving that he is totally disabled by a respiratory or pulmonary impairment. Based upon the opinions of Drs. Fino and Renn, supported as they are by the objective laboratory data of record and the treatment records, I find that total disability has not been established pursuant to 20 C.F.R. § 718.204(b)(2)(iv). As Claimant has failed to establish that he is totally disabled by a respiratory disease, he has failed to establish entitlement to benefits under the Act.

Total Disability Due to Pneumoconiosis

Even if the existence of a totally disabling respiratory impairment had been established, Claimant would still need to establish that that impairment had been caused by pneumoconiosis. 20 C.F.R. § 718.204(c). Claimant would need to establish by a preponderance of the evidence that his total disability was due to pneumoconiosis. *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986) (*en banc*). The amended Regulations require that the pneumoconiosis be a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Section 718.204(c)(1) sets forth that pneumoconiosis is a substantially contributing cause of disability if it either (1) has a material adverse effect on the miner's respiratory condition or (2) materially worsens a totally disabling respiratory impairment caused by a disease unrelated to coal mine employment.

In this case, the medical evidence submitted with the prior claim is insufficient to meet this burden of proof. To be considered with the subsequent claim, are the opinions of Drs. Illuzzi, Fino, Renn, Schaaf, and Begley. Drs. Begley and Schaaf found Claimant to be disabled due to coal workers' pneumoconiosis. Dr. Illuzzi's opinion was that lung disease contributed a small portion to Claimant's pulmonary disability. Drs. Fino and Renn found no disabling pulmonary impairment. For the reasons set forth above, I find the opinions of Drs. Fino and Renn to be the more persuasive on this issue. I do not find that Drs. Schaaf and Begley sufficiently explain their conclusions in light of the objective laboratory data. Dr. Begley finds no cardiac disability despite the overwhelming evidence to the contrary, and Dr. Schaaf also appears to not fully consider the consequences of Claimant's cardiac condition and other

factors which most likely are causing his breathlessness. Dr. Illuzzi's finding that Claimant's lung disease played a small role is not sufficient to meet Claimant's burden or proof and indeed, I do not find it sufficient to outweigh the contrary opinions of Drs. Renn and Fino. Based upon their well-reasoned and well-documented medical opinions, I find that Claimant has failed to establish that his disability is due to coal mine dust exposure pursuant to 20 C.F.R. § 718.204(c).

Conclusion

As Claimant has failed to establish all elements of entitlement, I find that he has failed to establish entitlement to benefits under the Act.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered to him in pursuit of this claim.

ORDER

IT IS HEREBY ORDERED that the claim of John T. Sickon for benefits under the Act is DENIED.

A

MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).